MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-5

0867

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
12 Murray Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 12 Murray Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Viola Wadley Amass

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George H. Amass

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 13, 1891

8. AGE: Years	Months	Days	If less than one day
54	3	16	____ hrs. ____ min.

9. Birthplace: Annapolis, A.A.Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: George E. Wadley

13. Birthplace: Annapolis, Md.

MOTHER — 14. Maiden name: Elizabeth Russell

15. Birthplace: Annapolis, Md.

16. Informant: George E. Wadley

Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 30, 1945 (month) (day) (year)

Cemetery or crematory: St. Anne's Cemetery

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. Sept 30 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28th 1945, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec, 1944, to Sept 28 1945 and that I last saw h.. alive on Sept 26th 1945

Immediate cause of death	DURATION
Generalized Carcinomatosis	1 year
Due to: Primary carcinoma of liver. Duration: one year. C.w.j.A.	
Due to:	
Other conditions: Moderate Arteriosclerosis	autumn

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: George C Boyd, M. D. or other

Address: Annapolis Md Date signed 10-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

CERTIFICATE OF DEATH

★ 8675 Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Arundel Place Weems Creek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Weems Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Arundel Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ella Virginia Atherton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George H. Atherton
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): June 21st 1883

8. AGE: Years	Months	Days	If less than one day
62	2	29	____ hrs. ____ min.

9. Birthplace: Baltimore Md
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Wm L Burch
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elednor A. Happoldt
15. Birthplace: Ballo Md

16. Informant: Mrs Clarence Ramsley
Address: 8 Arundel Place Nr. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 24th 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M. Taylor and Son
Address: Glaceite St. Annapolis

19. Sept 23 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18th 1945 at 8 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____ to ____ 19____ and that I last saw h____ alive on ____ 19____

Immediate cause of death	DURATION
Cerebral Hopleny	Sudden
Due to: Arterial Hypertension	Years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J Oliver Parrott M. D. or other
Address: Annapolis Md Date signed: 9/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

68676 — Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Sudbrook Heights
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Sudbrook Heights
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George W. Batts

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	W

6.(b) Name of husband or wife: Ella F. Shield
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 14th, 1863

8. AGE: Years	Months	Days	If less than one day
81	10	15	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Stationary Engineer
11. Industry or business: —
FATHER — 12. Name: —
FATHER — 13. Birthplace: —
MOTHER — 14. Maiden name: —
MOTHER — 15. Birthplace: —
16. Informant: Family
Address: Sudbrook Heights, Md.
17. (Burial, cremation, or removal. Which?) D. Date thereof 9-5-45 (month) (day) (year)
Cemetery or crematory: Bamshire Cem.
Location: Waynesboro, Pa.
18. Funeral director: James L. McCully
Address: 130 E. Fort Ave.
19. 9-2-45 (Date rec'd by registrar) L. A. Deer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 2 1945 at 4 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1941 19.. to Sept. 2 1945
and that I last saw him alive on Aug. 31 1945

Immediate cause of death	DURATION
Chronic arterio-sclerotic heart disease	
Due to: Arteriosclerosis	indefinite
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. A. Deer M. D.
M. D. or other
Address: Pasadena, Md. Date signed: 9-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

08677

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U. S. Naval Hospital

How long in hospital or institution? 6½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severna Park, Manhatten Beach.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: --

3.(a) FULL NAME

BABY GIRL BIRDSALL

3.(b) Social Security Number

--

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	infant

6.(b) Name of husband or wife: --

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
			6 hrs. 30 min.

9. Birthplace: Annapolis, Maryland

(Town, county, and state)

10. Usual occupation: --

11. Industry or business

FATHER

12. Name: Robert Birdsall

13. Birthplace: Tuxedo, N. Y.

MOTHER

14. Maiden name: Margaret Krauss

15. Birthplace: Baltimore, Md.

16. Informant: Robert Birdsall

Address: Severna Park, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 26, 1945 (month) (day) (year)

Cemetery or crematory: Naval Academy

Location: Annapolis Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis Md.

19. Sept. 26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 September 19 45 at 6:45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12:05 AM Sept. 25 19 45 to 6:45 AM 19 45

and that I last saw her alive on Sept. 25 19 45

Immediate cause of death	prematurity	6½ hrs.
Due to	prematurity	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harry Bowen M. D. or other

Address: U. S. Naval Hospital, Annapolis, Md. Date signed: 9-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1640)

CERTIFICATE OF DEATH

68678

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Arundel on the Bay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?: 7

Hospital, institution, or street address where death occurred:

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Arundel on the Bay

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Guthrie M. Boydstun

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Corrinne S. Boydstun

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 8th 1906

8. AGE: Years	Months	Days	If less than one day
39	3	23	hrs. min.

9. Birthplace: China (Town, county, and state)

10. Usual occupation: Welder

11. Industry or business:

FATHER — 12. Name: Irvin P. Boydstun

FATHER — 13. Birthplace: Miss.

MOTHER — 14. Maiden name: Mabel Martin

MOTHER — 15. Birthplace: Miss

16. Informant: Corrinne S. Boydstun

Address: Arundel on the Bay R.A.G. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4th 1945 (month) (day) (year)

Cemetery or crematory: Abbey Mausoleum

Location: Arlington, Va.

18. Funeral director: John M. Taylor, Inc.

Address: Annapolis Md.

19. Sept. 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1 1945, at 2-50 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination ~~and that I last saw him alive on~~ Sept. 1 1945

Immediate cause of death	DURATION
Suicide	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 9-1-45

Where did injury occur? Arundel on the Bay (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: 22 cal rifle. Injured at work? No

23. SIGNATURE: Thos M. Caffey Deputy Medical Examiner M. D. or other

Address: Annapolis Md Date signed: 9-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 2

8679

1. PLACE OF DEATH:
County Anne Arundel
City or town PASADENA
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County ANNE ARUNDEL
City or town PASADENA
(If outside city or town limits, write RURAL and give nearest town)
Street No. OLD ANNAPOLIS ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war W

3.(a) FULL NAME James Thomas Canavan

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 10 1945

8. AGE: Years | Months | Days 27 | If less than one day hrs. min.

9. Birthplace Pasadena Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name John J. Canavan
13. Birthplace Salina Calif.

MOTHER 14. Maiden name Mary Kidwell
15. Birthplace Baltimore Md

16. Informant Mrs Florence Garrison
Address Pasadena Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 10, 1945 (month) (day) (year)
Cemetery or crematory Glen Haven
Location Glen Burnie

18. Funeral director Williams & Son Inc
Address 1217 St Paul St Baltimore Md

19. Sept 8 1945 (Date rec'd by registrar) Mc Dealba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 7 1945, at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5th 1945, to Sept 7th 1945
and that I last saw h alive on Sept 7th 1945

Immediate cause of death	DURATION
Uro-cystitis.	1 wk
Due to	
Due to	
Other conditions Anuria Toxemia Hemorrhagic Diarrhoea.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J. Alexander M. D. or other
Address Glen Burnie Date signed 9/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52f)

CERTIFICATE OF DEATH

(8680 21) Reg. Diat. No.

1. PLACE OF DEATH:

County a. a

City or town annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

32 North Glenn ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Homewood

(If outside city or town limits, write RURAL and give nearest town)

Street No. 32 North Glen ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Aaron Bunion Chambers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
m	w	married

6.(b) Name of husband or wife Vasie J Chambers

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) march 14 - 1873

8. AGE: Years 72 | Months 5 | Days 16 | If less than one day ..... hrs. ..... min.

9. Birthplace Calvert Co md (Town, county, and state)

10. Usual occupation Printer

11. Industry or business Retired

FATHER 12. Name John Chambers

FATHER 13. Birthplace Calvert. Co.

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Unknown

16. Informant Vasie J Chambers

Address 32 N. Glen ave Homewood. md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4/45 (month) (day) (year)

Cemetery or crematory St Anns

Location annapolis md

18. Funeral director B L Hopkins

Address annapolis. md

19. Sept. 3 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 19 45 at 11 49 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25 19 45, to Sept 1 19 45

and that I last saw h... alive on Aug 31 19 45

Immediate cause of death	DURATION
Ca of bladder	8 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE S. Bounds MD M. D. or other

Address Annapolis Md Date signed 9/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

CHANGE of yr. of birth: Bible record, plus consistent age statement; Film G97 9-10-45 L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08681

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Tracy's Landing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A A Co
City or town: Tracey's Landing
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George William C Chambers

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Nellie Shipley
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 22. 1868 1867

8. AGE: Years	Months	Days	If less than one day
77	9	11	hrs. min.

9. Birthplace: Calvert Co. Md. (Town, county, and state)
10. Usual occupation: General Laborer
11. Industry or business
FATHER 12. Name: David C Chambers
13. Birthplace: Calvert Co. Md.
MOTHER 14. Maiden name: Virginia Ellen Ogden
15. Birthplace: Calvert Co. Md.
16. Informant: Mrs Allen Maryland
Address: Tracys Landing
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-6-45 (month) (day) (year)
Cemetery or crematory: Upper Marlboro
Location: Upper Marlboro, Md
18. Funeral director: Harry Hutchins
Address: Owings, Md.
19. Sept 4 1945 (Date rec'd by registrar) W. R. Clagett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 3 1945, at 5:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 27 1945, to Sept 3, 1945 and that I last saw h[illegible] alive on August 28 1945.

Immediate cause of death	DURATION
Myocarditis C Chronic	7
Due to: Arthritis, C Chronic	?
Due to:	
Other conditions: Contributing Existing Acute	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F B Heat M.D. M. D. or other
Address: Pokiac Md Date signed 9/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-a)

CERTIFICATE OF DEATH

08682

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, Institution, or street address where death occurred:
47 Fleet St. Annapolis Md.

How long in hospital or institution? ***********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 47 Fleet St Annapolis
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Charles Edward Connor

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife: **********

6.(c) If alive, give age: *** years

7. Birth date of deceased (mo., day, yr.): June 30, 1894

8. AGE: Years	Months	Days	If less than one day
51 51	2	4	hrs. min.

9. Birthplace: Baltimore City
(Town, county, and state)

10. Usual occupation: General Utility Man

11. Industry or business: None

FATHER
12. Name: Thomas Edward Harrison Connor
13. Birthplace: Baltimore City

MOTHER
14. Maiden name: Kate Virginia Parks
15. Birthplace: Baltimore City

16. Informant: Mrs. Bessie Simpskins
Address: 47 Fleet St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/6/45 (month) (day) (year)

Cemetery or crematory: Brew Hill Cemetery

Location: West St. Extd. Annapolis Md.

18. Funeral director: Mrs. Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. Sept. 6 1945 (Date rec'd by registrar) Registrar: B.W.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 3 1945 at 10:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Postmortem Examination, and that I last saw h[illegible] alive on Sept. 3 1945

Immediate cause of death	DURATION
Cardio-renal disease	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: John M. Caffey M.D., Deputy Medical Examiner
M. D. or other

Address: Annapolis Md. Date signed 9-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH ★

08683

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 1 day

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 month, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: ---

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 5 South Durham
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: DOOSE - JOHN

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Ella Doose, 5 S. Durham St., Baltimore, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1896 ?

8. AGE: Years	Months	Days	If less than one day
49 ?	unknown		--- hrs. --- min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ---

FATHER
12. Name: Mac Doose
13. Birthplace: Virginia

MOTHER
14. Maiden name: Lu Spencer
15. Birthplace: Virginia

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) Sept 11 1945

Cemetery or crematory: Int Calvary

Location: ---

18. Funeral director: Elroy O. Wilson

Address: 1000 Brantley ave

19. (Date rec'd by registrar) 9/8 45 Registrar E.T. Joyce Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1945, at 7:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 6 1945 to Sept. 7 1945 (im) and that I last saw h... alive on Sept. 7 1945

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 8/6/45
Due to: ---	
Due to: ---	
Other conditions: Psychosis with Cerebral Arteriosclerosis	

(Include pregnancy within 3 months of death) ---

Major findings of operations: ---

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ---

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed 9/7/45

MARGIN RESERVED FOR BINDING

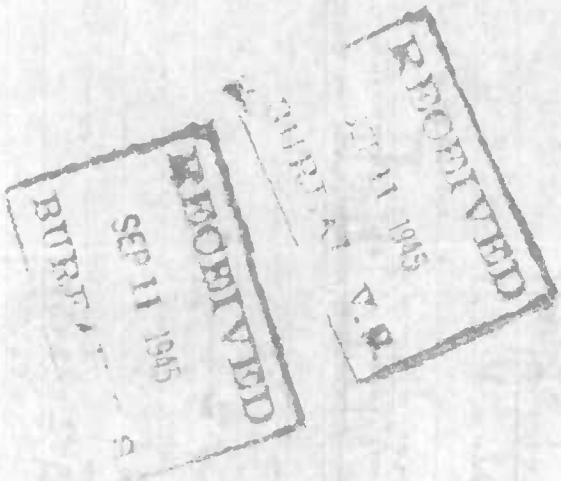
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

9401

Doose - John
Baltimore City
Admitted - August 6, 1945

Died - September 7, 1945



Evidence for change of date of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08684

FILE No. 100 JAN 8 1946

Reg. Dist. No. 20

1. PLACE OF DEATH:

County: Balto Co

City or town: Catonsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Balto Co

City or town: Catonsville Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Thomas Dawson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 7, 1945

8. AGE: Years: 4 | Months: | Days: | If less than one day: ____ hrs. ____ min.

9. Birthplace: Edgewater Anne Arundel Co. Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: James Dawson

13. Birthplace: West River

MOTHER

14. Maiden name: Elizabeth Foote

15. Birthplace: Edwardstone

18. Informant: Robert Foote

Address: Edgewater

17. Burial, cremation, or removal. Which? Burial Date thereof: Sept 13, 1945 (month) (day) (year)

Cemetery or crematory: Daniel Star

Location: Catonsville, Md.

18. Funeral director: T. G. Hagerty & Son

Address: Catonsville Md.

19. Sept 13 1945 (Date rec'd by registrar) M. M. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13, 1945, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 13 1945 to Sept 13 1945 and that I last saw h[illegible] alive on Sept 13, 1945

Immediate cause of death	DURATION
Infantile Diarrhoea	
Due to Malnutrition	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: F B Smith M. D. or other

Address: Catonsville Md. Date signed: 9/13/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B/a)

CERTIFICATE OF DEATH

08685

Reg. Diat. No. 20

1. PLACE OF DEATH:

County a a

City or town Lothian

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Lothian

(If outside city or town limits, write RURAL and give nearest town)

Street No. Bagust Rd R 21

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joshua Thomas Estep

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widower

6.(b) Name of husband or wife Essie E. Estep

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 2 — 1863

8. AGE: Years	Months	Days	If less than one day
81	10	4	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER

12. Name Thomas Estep

13. Birthplace Maryland

MOTHER

14. Maiden name Emily Cross

15. Birthplace Maryland

16. Informant Eva D Estep

Address Lothian

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 8-1945 (month) (day) (year)

Cemetery or crematory Mt Zion

Location Mt Zion

18. Funeral director B L Hopkins

Address Annapolis - Md

19. Sept 7 1945 (Date rec'd by registrar) H. H. Claxton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1945, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 27 1942, to Sept 6 1945 and that I last saw him alive on Sept 4, 1945

Immediate cause of death	DURATION
Myocarditis Arterio	5 yrs
Due to Nephritis C Arterio	5 yrs ?
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE F B Dent M. D. or other

Address Lothian Md Date signed 9/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

08686

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Jacobsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Jacobsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish-American

3. (a) FULL NAME: CHARLES FELDHAUS

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Laura Feldhaus
6.(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1872

8. AGE: Years	Months	Days	If less than one day
73	7	7	....hrs. ....min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Chauffeur (retired)
11. Industry or business

FATHER
12. Name: Charles Feldhaus
13. Birthplace: Md

MOTHER
14. Maiden name: Amelia ?
15. Birthplace: Md.

16. Informant: Laura Feldhaus
Address: Jacobsville, P. O. Pasadena, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-13-45 (month) (day) (year)
Cemetery or crematory: U. S. Ntl. Cemetery
Location: Baltimore, Md.

18. Funeral director: Wm. Cook
Address

19. 9-10 19 45 L. A. Pleis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10 1945, at 6.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 1945, to date 19....
and that I last saw h....alive on Sept. 7 1945

Immediate cause of death	DURATION
Cerebral hæmorrhage	sudden
Due to: Arteriosclerosis	unknown
Due to:	
Other conditions: Arteriosclerotic heart disease	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L. A. Pleis M. D.
M. D. or other
Address: Pasadena, Md. Date signed: 9-10-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-2)

CERTIFICATE OF DEATH

08687

Reg. Diat. No. 225

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A. A. Co. 231 Townsend Ave

City or town: Brooklyn Heights

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Md. County: A. A. Co.

City or town: Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4409 Ritchie Highway

(If rural, give LOCATION)

2.(a) If veteran, name war: No.

3. (a) FULL NAME: Mary E. Ford

3. (b) Social Security Number: No.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry Ford

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Dec 10, 1876

8. AGE:

Years	Months	Days	If less than one day
68	9	4	hrs. min.

9. Birthplace: Balto Md

(Town, county, and state)

10. Usual occupation: Cab Driver

11. Industry or business

FATHER

12. Name: Brownlee

13. Birthplace: Va.

MOTHER

14. Maiden name: Dent Brown

15. Birthplace: Va.

16. Informant: Harry Ford

Address: 4409 Ritchie Highway

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 18, 1945 (month) (day) (year)

Cemetery or crematory: Mt Olivet

Location: Balto

18. Funeral director: A. Howard Evans

Address: 1400 St Paul St

19. Sept 15 1945 (Date rec'd by registrar) Ida M. Whitem Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14, 1945, at 5-20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1943, to Sept 14 1945

and that I last saw h alive on Sept 14 1945

	DURATION
Immediate cause of death: Uremia	
Due to: Hypertension	
Due to: Chronic vascular renal disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Samuel Chilcoat M.D.

M. D. or other

Address: 203 Old Annapolis Rd. Date signed: 9/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93)

CERTIFICATE OF DEATH

C8688

Reg. Dist. No. 20

1. PLACE OF DEATH:
County Anne Arundel
City or town Mayo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County A. A.
City or town Mayo. MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME CATHERINE VIRGINIA GARDNER

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife George T. Gardner. 6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) March 16, 1890

8. AGE: Years	Months	Days	If less than one day
55			hrs. min.

9. Birthplace Broomes Island. Calvert Co. MD. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William Horsman
13. Birthplace MD.

MOTHER 14. Maiden name Sally Ward.
15. Birthplace MD.

16. Informant George Gardner
Address Mayo

17. Burial Date thereof Sept 16, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mayo Memorial
Location Mayo

18. Funeral director D. C. Stahlnecker & Son
Address Galesville Md

19. Sept 16 1945 Edw. Collinson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 13. 1945 at 5 05 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1942 to Sept 13 1945
and that I last saw h alive on Sept 12 1945

Immediate cause of death	DURATION
cerebral hemorrhage	10 days
Due to arteriosclerotic cardiovascular disease	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE S. Bosworth MD
M. D. or other
Address Annapolis Md Date signed 9/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08689

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 10

CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Green Haven
City or town Arundel County (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? two weeks
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Balto
City or town Balto (If outside city or town limits, write RURAL and give nearest town)
Street No. 1003 S. Kenwood (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARY
Mary A. Glock

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: John Westley Glock
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Jan 1, 1875

8. AGE: Years 70 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: Balto Md (Town, county, and state)
10. Usual occupation: housework
11. Industry or business

FATHER
12. Name: John Westley Adams
13. Birthplace: Balto Md

MOTHER
14. Maiden name: unknown
15. Birthplace: Balto Md

16. Informant: Mrs. Rose Henshaw
Address: Green Haven

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Oak Lawn Oct. 2/45
Location: Eastern Ave

18. Funeral director: Stephen J. Fialkowski INC
Address: 1000 S. KENWOOD Ave

19. 10-1-45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27-45, 8:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 20-45 to Sept 27-45 and that I last saw her alive on Sept 27-45

Immediate cause of death: Lobar Pneumonia — DURATION: 4 days
Due to: Chronic Myocarditis — unknown
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE [signature] M.D. or other
Address: Glen Burnie Md
Date signed: Sept 27-45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125-t)

CERTIFICATE OF DEATH

08690

★ Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 yrs, 11 mos, 9 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 yrs, 11 mos, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Catholic Charities
(If rural, give LOCATION)
2.(a) If veteran, name war: ------ ✓

3.(a) FULL NAME: GRAY - JOSEPH LOUIS

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: --------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): February 23, 1930

8. AGE: Years	Months	Days	If less than one day
15	6	28	----hrs. ----min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: none
11. Industry or business: ----

FATHER
12. Name: Paul Gray
13. Birthplace: St. Mary's County, Maryland

MOTHER
14. Maiden name: Lizzie ?
15. Birthplace: St. Mary's County, Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/4/45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt. of Hospital
Address:

19. (Date rec'd by registrar) Oct 4 1945 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 21 19 45, at 4:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 12 19 38, to Sept. 21 19 45
and that I last saw him alive on September 21 19 45

Immediate cause of death	DURATION
Disease of the Liver (Jaundice)	
Due to: --------	
Due to: --------	
Other conditions: Congenital Idiocy	Known to us since 10/12/38

(Include pregnancy within 3 months of death)

Major findings of operations: ---------
Date of op.: -----
Autopsy results: ----------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: -------- Date of: ------
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----------
Means of injury: ------ Injured at work? ------

23. SIGNATURE: Hal T. Kintzer M. D. or other
Address: Crownsville, Maryland Date signed 9/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30-B

08691

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 20 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 3 months, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Anderson Road

(If rural, give LOCATION)

2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME: GREEN - WALTER

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Edna Green, Salisbury, Maryland 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1889 ?

8. AGE: Years	Months	Days	If less than one day
56 ?	unknown		---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Farm Worker

11. Industry or business: -----

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 8, 1945 (month) (day) (year)

Cemetery or crematory: Quanticio, Wicomico County

Location: Eastern Shore, Maryland

18. Funeral director: B. L. Hopping

Address: Annapolis, Maryland

19. Sept. 7 1945 (Date rec'd by registrar) E. Joyce Loar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 5 1945, at 8:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945 to Sept. 5 1945 and that I last saw him alive on Sept. 5 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 5/29/45
Due to: -------	
Due to: -------	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------

Date of op.: -----

Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: -------- Date of: -----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: ---------- Injured at work? -----

23. SIGNATURE: H. M. Hinkerd M. D. or other

Address: Crownsville, Maryland Date signed: 9/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

08692

★ Reg. Dist. No. 26

1. PLACE OF DEATH:

County: Pa

City or town: Sladyde

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mo

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: aa

City or town: Sladyde

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Martha Virginia Griffin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife —

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.) Dec 29, 1871

8. AGE:

Years	Months	Days	If less than one day
73	8	18	hrs. min.

9. Birthplace Va

(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Henry R. Biggs

13. Birthplace Va

MOTHER 14. Maiden name Martha E Slaven

15. Birthplace Md

16. Informant Mrs Helen D. Smithridge

Address Sladyde Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 19 1945 (month) (day) (year)

Cemetery or crematory Catholic Cemetery

Location Owensville Md

18. Funeral director J. A. Hendrickson & Son

Address Baltimore Md

19. Sept 18 1945 (Date rec'd by registrar) D. B. Deist Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/16 1945, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1945, to Sept 16 1945 and that I last saw h alive on Sept 8 1945

Immediate cause of death	DURATION
Enterocolitis	5 yr
Due to: Hypostatic pneumonia	1 wk
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exteroat causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. Wilson M. D. or other

Address Owensville Md Date signed 9/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evening
Star Paper

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

18693

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County a a

City or town Harmans creek
(If outside city or town limits, write RURAL and give nearest town)

Street No. Near Annapolis
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Elizabeth K Hagood

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 7 - 1929

8. AGE:

Years	Months	Days	If less than one day
16	3	25	hrs. min.

9. Birthplace Texas
(Town, county, and state)

10. Usual occupation School Girl

11. Industry or business

FATHER
12. Name Kyle Hagood
13. Birthplace Texas

MOTHER
14. Maiden name Allie Fragier
15. Birthplace Texas

16. Informant Kyle Hagood
Address Annapolis R.F.D.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof Sept 7 - 1945
(month) (day) (year)

Cemetery or crematory Glen Haven

Location Glen Burnie

18. Funeral director C. L. Hopping

Address Annapolis, Md.

19. Sept 3, 1945
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 1, 1945, at 9.40 P. M.

21. I CERTIFY that death occurred on the date above stated: (1) I attended deceased from Post mortem Examination

and (2) I last saw h alive on Sept 1 1945

Immediate cause of death Fracture of neck — DURATION

Due to Hemorrhage laceration

Due to Brain, subarachnoid

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-1-45

Where did injury occur? Near Annapolis - A.A. Maryland
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) near Bells Corner

Means of injury automobile collision Injured at work? No

23. SIGNATURE John M. Flaherty M.D. Deputy medical Examiner
M. D. or other

Address Annapolis Md Date signed 9-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

08694

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DEACEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Davidsonville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Clyde ~~Lee~~ M. Hall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 14 1945

8. AGE: Years	Months	Days	If less than one day
	6		..... hrs. ..... min.

9. Birthplace Davidsonville Md

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Leo M Hall

FATHER 13. Birthplace Davidsonville Md

MOTHER 14. Maiden name Jessie Lee Hopkins

MOTHER 15. Birthplace Calvert Co

16. Informant Leo. M. Hall

Address Davidsonville. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1 45 (month) (day) (year)

Cemetery or crematory St. Mary's

Location Annapolis. Md

18. Funeral director B I Hopkins

Address Annapolis Md

19. Oct. 1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 30 1945 at 9 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1945 to Sept 30 1945

and that I last saw h.. alive on Sept 29 1945

Immediate cause of death	DURATION
malnutrition	5 mos (?)
Due to	
Due to	
Other conditions Avitaminosis	
W Anemia, dehydration	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. Brooks MD

M. D. or other

Address Annapolis Md Date signed 10/1/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08695

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Rhodesdale
(If outside city or town limits, write RURAL and give nearest town)

Street No. ---

(If rural, give LOCATION)

2.(a) If veteran, name war ---

3.(a) FULL NAME: HARRIS - ALBERT

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Eunice Harris,
Rhodesdale, Md. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1890

8. AGE: Years	Months	Days	If less than one day
55	unknown		--- hrs. --- min.

9. Birthplace: unknown
(Town, county, and state)

10. Usual occupation: unknown

11. Industry or business: ---

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

18. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: Sept. 27, 1945
(month) (day) (year)

Cemetery or crematory ---

Location: Vienna, Maryland

18. Funeral director: J. J. Framptom & Sons
Address: Federalsburg, Maryland

19. Sept 24 1945
(Date rec'd by registrar)
E. F. Joyce
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23 1945 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 8 1945 to Sept. 23 1945 and that I last saw him alive on September 23 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 9/8/45
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op. ---

Autopsy results ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- Injured at work? ---

23. SIGNATURE: Herbert V. Hinkle
M. D. or other

Address: Crownsville, Maryland Date signed: 9/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition of county of death is shown on FILM No. G 98 SEP 18 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

08696

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brown Woods

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brownswood

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Dennis Harrold

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 21, 1923

8. AGE: Years	Months	Days	If less than one day
21	10	15	..... hrs. ..... min.

9. Birthplace: Anne Arundel Cunty and (Town, county, and atate)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Dennis Harrold

13. Birthplace: Norfolk Va

MOTHER

14. Maiden name: Lena Stanberry

15. Birthplace: Anne Arundel Cunty Md

16. Informant: Lena Harrold

Address: Brown Woods Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 11. 1945 (month) (day) (year)

Cemetery or crematory: Broad Neck cemetery

Location: Anne Arundel Cunty Md

16. Funeral director: Joseph A. Livelly

Address: 1890 Mount Street Baltimore and

19. Sept 10 19 45 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 6, 1945, at 5:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28, 1945, to September 6, 1945 and that I last saw him alive on September 6, 1945

Immediate cause of death: Kidney Disease	DURATION: 6 wks.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please nuderline the cause to which death should he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Dr. Theodore H. Johnson M.D. M. D. or other

Address: 35 Northwest Street Date signed: 9/8/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

8697

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 9 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: -------
City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No.: 1322 Pennsylvania Avenue (If rural, give LOCATION)
2.(a) If veteran, name war: ------ V

3. (a) FULL NAME: HAWKINS - LAURA

3. (b) Social Security Number: ---------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ---------
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1895

8. AGE: Years: 50 Months: unknown Days: own If less than one day: ----- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: None
11. Industry or business: ----

MOTHER FATHER
12. Name: John Hawkins
13. Birthplace: Maryland
MOTHER
14. Maiden name: Narcisse (unknown)
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof 9/21/45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Asylum Hospital
Address: Crownsville Md

19. 9/21/45 (Date rec'd by registrar) E T Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 19 45 at 7:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2 1945 to Sept. 11 1945 and that I last saw her alive on September 11 1945

Immediate cause of death: Chronic Myocarditis — DURATION: Known to us since 8/2/45
Due to: -------
Due to: ---------
Other conditions: Senile Dementia - Simple Deterioration
(Include pregnancy within 3 months of death)

Major findings of operations: ---------
Date of op.: -------
Autopsy results: ---------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: -----
Where did injury occur? --------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: ------ Injured at work? ----

23. SIGNATURE: Harold D. Amsbury M. D. or other
Address: Crownsville, Maryland Date signed: 9/11/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

08698

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2 Taney Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2 Taney Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Margaret Ann Hayes

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If olive, give age: — years

7. Birth date of deceased (mo., day, yr.): October 11, 1943

8. AGE: Years	Months	Days	If less than one day
1	10	27	...hrs. ...min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Merrill B. Hayes

13. Birthplace: Pennsylvania

MOTHER — 14. Maiden name: Margaret L. Fox

15. Birthplace: Troy, New York

16. Informant: Mrs. M. B. Hayes - Mother

Address: 2 Taney Ave.

17. ~~Burial~~ REMOVAL (Burial, cremation, or removal. Which?) Date thereof: Sept 7th 1945 (month) (day) (year)

Cemetery or crematory:

Location: Gardiner Maine

18. Funeral director: John M. Taylor and Son

Address: 147-149 Gloucester St. Annapolis

19. Sept 7 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1945 about 9 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Accidental Drowning	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Drowning Date of 9-7-45

Where did injury occur? Annapolis (City or town) Co. (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury: Drowning Injured at work?

23. SIGNATURE: Walton H. Hopkins M.D.

Deputy Medical Examiner (Official capacity or other)

Address: Balto. & Md. Ave. Date signed: 9-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57

08699

CERTIFICATE OF DEATH

★ Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Marley Park, P.O. Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7th Year.
Hospital, institution, or street address where death occurred: The Freeway Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Marley Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: The Freeway
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mrs. Mildred B. Henry.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Married.

6.(b) Name of husband or wife: Herbert Henry
6.(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): 4/7/1887

8. AGE:

Years	Months	Days	If less than one day
45	4	25	....hrs. ....min.

9. Birthplace: Crisfield - Eastern Shore, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
12. Name of father: Johnson Rogers
13. Birthplace of father: Maryland
14. Maiden name of mother: ?
15. Birthplace of mother: ?
16. Informant: Herbert Henry (husband)
Address: Marley Park, Md.
17. Burial (Burial, cremation, or removal? Which?) Date thereof: Sept 29, 1945 (month) (day) (year)
Cemetery or crematory: Glen Haven Cem.
Location: Glen Burnie, Md.
18. Funeral director: Thomas W. Dean Estate
Address: Glen Burnie, Md.
19. Sept 29, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27, 1945, at 9 45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 10, 1945, to Sept. 26, 1945, and that I last saw h.. alive on 9/26/1945.

Immediate cause of death	DURATION
Heart failure	
Due to ~~Hypertension~~ OSTEOARTHRITIS	7 years
Due to Malnutrition	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: ..... Injured at work?

23. SIGNATURE: Gustave A. Bauer M.D.
M. D. or other
Address: Glen Burnie Md. Date signed: 9/27/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (183)

08701 P

CERTIFICATE OF DEATH

Reg. Diat. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne arundel

City or town Point Pleasant – R.D. Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 3 hrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For person of infants give residence of mother)

State [redacted] County Norfolk

City or town Dedham

(If outside city or town limits, write RURAL and give nearest town)

Street No. 38 spruce st.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME David Irving Hill

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	M.

6.(b) Name of husband or wife althea P. Hill

6.(c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) Dec. 2nd 1920

8. AGE: Years	Months	Days	If less than one day
24	10	17	..... hrs. ..... min.

9. Birthplace Dedham – mass. (Town, county, and state)

10. Usual occupation chief machinist

11. Industry or business Coast Guard.

FATHER 12. Name Don J. Hill

13. Birthplace

MOTHER 14. Maiden name

15. Birthplace

16. Informant U.S. Coast Guard Record.

Address U.S.S. manhasset –

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 22 1945 (month) (day) (year)

Cemetery or crematory

Location Boston Mass

18. Funeral director Pratt & B. M. Walters

Address Pratt & Stricker Sts

19. 9-21-45 (Date rec'd by registrar) 19..... City R.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1945, at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death	
Accidental Drowning	Instantly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 9/19/45

Where did injury occur? Point Pleasant, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Bradley creek.

Means of injury Drowning. Injured at work? No

23. SIGNATURE Gustave A. Pamberton M.D. or other

Address Glen Burnie Md. Date signed 9/20/45

Evidence for the change of date of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18-d

CERTIFICATE OF DEATH

8702

File No. G 99 NOV 1 1945

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Anne Arundel

City or town: Annapolis R.F.D. (If outside city or town limits, write RURAL and give nearest town)

Street No.: St Margaret's (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Barbara Jean Hooper

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Single

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 8, 1945

8. AGE: Years | Months: 2 | Days: 29 | If less than one day: hrs. min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER — 12. Name: Milford H Cooper

FATHER — 13. Birthplace: Pen Argyl Pa

MOTHER — 14. Maiden name: Marion Catlin

MOTHER — 15. Birthplace: Providence R.I.

16. Informant: Milford H Hooper

Address: Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 8th 1945 (month) (day) (year)

Cemetery or crematory: Naval Academy Cemetery

Location: Annapolis Md

18. Funeral director: John M Taylor and Son

Address: Annapolis Md.

19. Sept 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 7 1945 at Not Known M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Due to: Suffocation	Sudden
Due to: Strangulation from vomiting	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Walton H. Hopkins M. D. or other

Address: Annapolis Date signed: 9-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1946
83
62

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-f)

CERTIFICATE OF DEATH

18703

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Annapolis R.F.D. #3
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Edgar E. Hopkins

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary J. Hopkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 26, 1870

8. AGE: Years	Months	Days	If less than one day
75	5	20	..... hrs. ..... min.

9. Birthplace: Annapolis A.A. Md.
(Town, county, and state)

10. Usual occupation: Carpenter

11. Industry or business

FATHER
12. Name: Henry Hopkins
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Edgar R. Hopkins
Address: R. F. D. #3, Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 19, 1945 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis, Md.

18. Funeral director: John M. Taylor & Son

Address: Annapolis, Md.

19. Sept 19 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept-16 1945 at 9.58 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5-16 1945 to Sept 16 1945

and that I last saw him alive on Sept 16 1945

	DURATION
Immediate cause of death: Stomach Carcinomatosis	1 month
Due to: Cancer of Liver	1 month
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other

Address: Annapolis Md. Date signed: 9/18/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for the change of date of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

08700

FILE No. G 98 OCT 26 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town St Margarets
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A a
City or town St Margarets
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Unnamed Howard Barth Gertrude

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 15 1945

8. AGE: Years | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace St Margarets Md (Town, county, and state)

10. Usual occupation infant

11. Industry or business

FATHER 12. Name Oscar Howard
13. Birthplace A a Co Md

MOTHER 14. Maiden name Louise Ireland
15. Birthplace A a Co Md

16. Informant Louise Ireland
Address St Margarets Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 17, 45 (month) (day) (year)

Cemetery or crematory Broadneck
Location St. Margarets

18. Funeral director J. B. Thomas
Address Annapolis

19. Sept 17 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1945 at 4 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Premature birth, 7 month Gestation	
Due to Atelectasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Walbert H Hopkins M.D. or other
Address Deputy Medical Exr Md Date signed 9-17-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

08704

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Harwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Harwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George Early Johnson

3. (b) Social Security Number:

4. Sex: M | 5. Color or race: Col | 6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of husband or wife: Pearl Johnson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 7 1889

8. AGE: Years: 55 (55) | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Harwood Md.
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business

FATHER — 12. Name: James Henry Johnson

13. Birthplace: Md

MOTHER — 14. Maiden name: Charlotte Howard

15. Birthplace: Md

16. Informant: Pearl Johnson

Address: Harwood

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 30, 1941 (month) (day) (year)

Cemetery or crematory: Watkins Chapel Moses.

Location: Hwy.

18. Funeral director: F. A. Stanley & Son

Address: Galesville, Md.

19. Sept 30 41 (Date rec'd by registrar) W. H. Gaylor Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 28 1941, at 7:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1941 to Sept 28 1941 and that I last saw h.. alive on 9/27 1941

Immediate cause of death	DURATION
a Pneumonia	1wk
Due to: Diabetes	1wk
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. Heward M. D. or other

Address: Owings Md. Date signed: 9/28/41

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 168

08705

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH

County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 days

Hospital, Institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Galesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Richard Johnson

3.(b) Social Security Number 214-12-8691

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	Married

6.(b) Name of husband or wife: Alberta Johnson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1909

8. AGE: Years: 36 Months: Days: If less than one day: hrs. min.

9. Birthplace: Sudley, Md. (Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

FATHER — 12. Name: Arthur Johnson

13. Birthplace: A. A. Co.

MOTHER — 14. Maiden name: Agnes Duvall

15. Birthplace: West River, Md.

16. Informant: Rosie Johnson

Address: Galesville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 9. 1945 (month) (day) (year)

Cemetery or crematory: Ebenezer Cemetery

Location: Galesville, Md.

18. Funeral director: J. G. Franklin & Son

Address: Galesville, Md.

19. Sept 5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

35

20. DATE OF DEATH: Sept 5 1945 at 11 A. M.

21. I CERTIFY that death occurred on the date above stated. I attended deceased from Sept. 5 1945 to Sept. 5 1945

I last saw deceased on Sept. 5 1945

Immediate cause of death: Fracture of base of skull — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of 8-30-45

Where did injury occur? Galesville (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?) at home

Means of injury: Probably blunt instrument Injured at work? no

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner

M. D. or other

Address: Annapolis, Md. Date signed: 9-5-45

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(95a)

08706 20-

Reg. Diat. No.

1. PLACE OF DEATH:
County Anne Arundel
City or town Mayo Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since June 1 - 1945
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town Washington DC
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2924 Macomb St
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME JOHN BRECKENRIDGE KINNEAR

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Anna C. Kinnear
6.(c) If alive, give age 82 years
7. Birth date of deceased (mo., day, yr.) November 23rd 1857

8. AGE: Years	Months	Days	If less than one day
87	9	16	...hrs. ...min.

9. Birthplace McGrawsboro Del.
(Town, county, and state)
10. Usual occupation Retired Realtor
11. Industry or business
FATHER 12. Name James W. Kinnear
13. Birthplace Delaware
MOTHER 14. Maiden name Charlotte Fairwather
15. Birthplace Delaware
16. Informant Mrs G. K. von Tschebrog
Address Mayo Anne Arundel Co Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 11 - 19 (month) (day) (year)
Cemetery or crematory Arlington Memorial Abbey
Location Arlington Va
18. Funeral director The S. H. Hines Co.
Address 2901 - 14th St NW
19. Sept 8 19 45 (Date rec'd by registrar) Carrie Shiff Registrar
Rec'd Sept 13 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH September 8 19 45 at 5:15 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9 19 45 to Sept 8 19 45
and that I last saw him alive on Sept 8 19 45

Immediate cause of death	DURATION
Cerebro-Vascular Failure	Auth Yrs
Due to Adams Stokes Disease	Unknown Yrs
Due to	Yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Oliver Purvis M. D. or other
Address Annapolis Md. Date signed 9/8/45

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

(170-2)

State File No. _____

Registrar's No. 27 08707

State of Maryland

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Ft Geo. G. Meade (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Regional Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 2 days; In this community 2 days (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State W. Va. (b) County –
(c) City or town Parsons (If outside city or town limits, write RURAL)
(d) Street No. Box 331 (If rural, give location)
(e) If foreign born, how long in U. S. A.? – years. ✓

3. (a) FULL NAME Philip N. KNICLEY 7026214
3. (b) If veteran, name war –
3. (c) Social Security No. –
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Myrtle M. Knicely
6. (c) Age of husband or wife if alive – years
7. Birth date of deceased July (Month) 7, (Day) 1917 (Year)

8. AGE: Years	Months	Days	If less than one day
28	3	16	– hr. – min.

9. Birthplace Elkins, W. Va. (City, town, or county) (State or foreign country)
10. Usual occupation Soldier
11. Industry or business U. S. Army

MOTHER
12. Name Unknown
13. Birthplace – (City, town, or county) (State or foreign country)

FATHER
14. Maiden name Flora (unknown) Knicely
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Service Record
(b) Address U. S. Army
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Sept 29, 1945 (Month) (Day) (Year)
(c) Place; burial or cremation Parsons, W. Va. Minear F. H.
Howard N. Blight Jr.
18. (a) Signature of funeral director Howard Blight
(b) Address 4914 Belair Road, Baltimore, Md.
Frank J. Tollison
19. (a) Sept. 22/45 (Date received local registrar) (b) FRANK J. TOLLISON, Capt. (Registrar's signature) MAC.

MEDICAL CERTIFICATION

20. Date of death: Month Sept. day 22 year 1945 hour 1:00 A.M. minute –
21. I hereby certify that I attended the deceased from 20 SEPT, 1945, to 22 SEPT., 1945 that I last saw him alive on 22 September, 1945, and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death LACERATION OF THE BRAIN, SUBDURAL HEMATOMA – BASAL	
Due to FRACTURE OF SKULL, LEFT PARIETAL + PETROUS	
~~Due to~~ PORTION OF TEMPORAL.	
Other conditions SUBARACHNOID HEMORRHAGE (Include pregnancy within 3 months of death)	

Major findings:
Of operations –
Of autopsy As above

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) Accident
(b) Date of occurrence September 20, 1945
(c) Where did injury occur? near Frederick, Md. (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? U. S. Route #40 (Specify type of place)
While at work? No (e) Means of injury Auto

23. Signature William B. Hagan (M. D. or other) LTMC
Address Reg Hosp, Ft. Meade, Md. Date signed 9/22/45

8-6917

U. S. GOVERNMENT PRINTING OFFICE 16—13493

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

Reg. Diat. No. 08708 2 F

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months - 30 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2 months - 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore County

City or town: Towson

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Davis Lewis

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Black	Separated

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1895?

8. AGE: Years	Months	Days	If less than one day
50 years?			..... hrs. ..... min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Hospital records

Address: Crownsville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept. 6, 1945 (month) (day) (year)

Cemetery or crematory: Pleasant Rest

Location: Baltimore County

18. Funeral director: Byron Wright

Address: 721 Aisquith St., Balto., Md.

19. Sept 5 1945 (Date rec'd by registrar) E.T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 3 1945 at 6 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 4, 1945, to September 3, 1945

and that I last saw him alive on September 3, 1945

Immediate cause of death	DURATION
General arteriosclerosis	Known to us since 6-4-45
Due to	
Due to	
Other conditions: Pneumonia with cerebral arteriosclerosis (Include pregnancy within 3 months of death)	4

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harry J. Armacost M. D. or other

Address: Crownsville Date signed 9-3-45

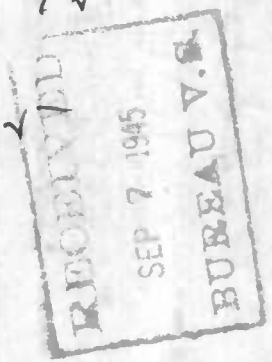
#9272

Davis Lewis

Baltimore County

Admitted:--- 6-4-44

Died:--- 9-3-44



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

CERTIFICATE OF DEATH

08709

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jacobsville, Pasadena, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Pasadena R F D

(If outside city or town limits, write RURAL and give nearest town)

Street No. Mountain Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Robert M. McCulley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant Single

6.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Dec 19, 1943

8. AGE:

Years	Months	Days	If less than one day
1	9	2	hrs. min.

9. Birthplace: Jacobsville, Pasadena Md R F D (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER

12. Name: Albert B. McCulley

13. Birthplace: Pasadena Md.

MOTHER

14. Maiden name: Hilda M. Fortman

15. Birthplace: Baltimore Co. Md

16. Informant: Mrs. Albert McCulley

Address: Pasadena Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 22 1945 (month) (day) (year)

Cemetery or crematory: New Haven Cem.

Location: New Burnid Md

18. Funeral director: Thomas E. Langston

Address: New Burnid Md

19. Sept 22 1945 (Date rec'd by registrar) M Rabbitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 21 19 45, at 1.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/17/45 19 to 9/21/45 19 and that I last saw h alive on 9/20/45 19

Immediate cause of death	DURATION
Bronchio Pneumonia	3 days
Due to, Due to, Other conditions: Pleuro colatis, Anemia congenital	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John [illegible] M. D. or other

Address: New Burnid Md Date signed 9/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

08710

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: ~~Sopa~~ Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?: —
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Rural - Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Epping Forest
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I and II

3. (a) FULL NAME: Clifton Mellen

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Esther Mellen
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 21, 1897

8. AGE: Years	Months	Days	If less than one day
48	8	6	..... hrs. ..... min.

9. Birthplace: Kent, Summit Co., Ohio (Town, county, and state)
10. Usual occupation: ret. Army Officer - Capt.
11. Industry or business

FATHER
12. Name: Robert Mellen
13. Birthplace: Summit Co., Ohio

MOTHER
14. Maiden name: Maude Brode
15. Birthplace: Ohio

16. Informant: Mrs. Esther Mellen
Address: Epping Forest

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 12 1945 (month) (day) (year)
Cemetery or crematory: Arlington Cemetery
Location: Virginia

18. Funeral director: John M. Taylor & Son
Address: Annapolis, Md.

19. Sept. 28 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27, 1945 at 3.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 24, 1945, to Sept 27, 1945 and that I last saw h.. alive on Sept. 27, 1945

	DURATION
Immediate cause of death: Epilepsy	Last 9/24/45
Due to:	
Due to: (Cause Tentative)	
Other conditions: None	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Gilbert H. Cameron M.D. M. D. or other
Address: Annapolis, Md. Date signed 9/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

copy

9433

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(306)

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 21 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 month, 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3.(a) FULL NAME MORRISON - ODELL

3.(b) Social Security Number unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Mamie Morrison, 203 Ridgeway Drive, Greensboro, N. Car. 6.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): December 28, 1896

8. AGE:	Years	Months	Days	If less than one day
	48	8	28	——— hrs. ——— min.

9. Birthplace: North Carolina (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER — 12. Name: Harrison Morrison

FATHER — 13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Lucy Crawford

MOTHER — 15. Birthplace: North Carolina

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept. 30, 1945 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetery

Location: Statesville, North Carolina

18. Funeral director: J. B. Johnson

Address: Annapolis, Maryland

19. ——— 19——— (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 26 19 45 at 1:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 19 45 to Sept. 26 19 45 and that I last saw him alive on September 26 19 45

Immediate cause of death	DURATION
General Paresis	Known to us since 8/5/45
Due to: ———	
Due to: ———	
Other conditions: ———	

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op. ———

Autopsy results: ———

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ——— Date of: ———

Where did injury occur? ——— (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ———

Means of injury: ——— Injured at work? ———

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 9/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-D)

CERTIFICATE OF DEATH

08711

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural - Moss Haven - Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8
Hospital, institution, or street address where death occurred:
Home
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Rural - Moss Haven - Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Moss Haven
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3. (a) FULL NAME: James Bayard Noble

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Marian Blanche Noble
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): July 24 1871

8. AGE:

Years	Months	Days	If less than one day
74	2	7	— hrs. 1 min.

9. Birthplace: Caroline Cty. Maryland (Town, county, or state)
10. Usual occupation: School administrator
11. Industry or business: Retired

FATHER
12. Name: Phillips Noble
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary Wilhemina Peters
15. Birthplace: Md.

16. Informant: Mrs. Marian O. Noble
Address: same

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27/45 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis, Md.
18. Funeral director: B. F. Hopkins
Address: Annapolis, Md.

19. Sept 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 25 19 45 at 1201 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 24 19 45 to Sept 25 19 45 and that I last saw him alive on 9-24-45 19

Immediate cause of death	DURATION
Coronary thrombosis -	2 wks
Due to: Atherosclerotic heart disease.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward P. MacKenzie M.D.
Address: 11 Maryland Ave Annapolis, Md. Date signed: 9/25/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

08712

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel County
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 47 Washington St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ellen H. B. Parker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colred	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 6. 1871

8. AGE:

Years	Months	Days	If less than one day
74	0	3	hrs. min.

9. Birthplace Anne Arundel Cnty and Md (Town, county, and state)
10. Usual occupation Musician
11. Industry or business

FATHER
12. Name Richard W. Brown
13. Birthplace Anne Arundel Co and

MOTHER
14. Maiden name Jane Dorsey
15. Birthplace Anne Arundel Co and

16. Informant Richard W. Brown
Address 17 Calvert street

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 14, 1945 (month) (day) (year)
Cemetery or crematory Bur Hill Cmetery
Location Anne Arundel Cnty and

16. Funeral director Joseph A. Levy
Address 661 W Lt Baltimore Md

19. Sept. 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept Fourteen 9 19 45, at 3:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 3, 19 45, to Septbr 9, 19 45
and that I last saw h alive on Septbr 9, 19 45

Immediate cause of death	DURATION
Cerebral Accident	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Dr. Hanford H. Johnson M. D. or other
Address 40 Northwest Street Date signed 9/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

08713 Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Harwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years.
Hospital, institution, or street address where death occurred: Drury.-
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Block St.-
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Josephine Johnson Parker

3.(b) Social Security Number: -

4. Sex: F.
5. Color or race: Black
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: William Parker
6.(c) If alive, give age: 28 years
7. Birth date of deceased (mo., day, yr.): February-2-1917

8. AGE: Years 28 Months 7 Days 13 If less than one day ... hrs. ... min.

9. Birthplace: Anne Arundel County, Md.
(Town, county, and state)
10. Usual occupation: Housekeeping.
11. Industry or business

FATHER
12. Name: John Johnson
13. Birthplace: Anne Arundel Co. Md.

MOTHER
14. Maiden name: Mary Eliza Johnson
15. Birthplace: Anne Arundel, Md.

16. Informant: Mary Eliza Johnson
Address: Drury - Harwood - P.O. Md.

17. Burial Date thereof: Sept 18 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory: Davidsonville Cem
Location: Davidsonville Md
18. Funeral director: G. C. Hardesty & Son.
Address: Galesville, Md.

19. Sept 18 1945 (Date rec'd by registrar) S. R. Clayton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 15 1945, at 9 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 — to 19
and that I last saw h... alive on 19

Immediate cause of death: Hemorrhage due to injury inflicted to mouth - by a charge from a shot-gun - No 12 - single barrel gauge.

	DURATION
Due to	Instantly
Due to	

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Homicide Date of: 9/15/1945
Where did injury occur? Harwood. A. A. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home
Means of injury Injured at work?

23. SIGNATURE: Gustave H. Faubert M.D. Assistant medical examiner M.D. or other
Address: Glen Burnie Md Date signed: 9/16/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (103)

08714

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:
County Anne Arundel
City or town Marley Station Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 924 Jordan St.
(If rural, give LOCATION)
2.(a) If veteran, name war V

3.(a) FULL NAME Leon Paul

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	B.	married.

6.(b) Name of husband or wife Elsie White
6.(c) If alive, give age 35 years
7. Birth date of deceased (mo., day, yr.) Sept. 8 - 1908

8. AGE: Years	Months	Days	If less than one day
36			hrs. min.

9. Birthplace Baltimore, Md.
(Town, county, and state)
10. Usual occupation Paperhanger.
11. Industry or business
FATHER 12. Name
13. Birthplace
MOTHER 14. Maiden name
15. Birthplace
16. Informant Elsie Paul (wife)
Address Marley Station
17. Burial Date thereof Sept 10 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Calvary
Location
18. Funeral director Adolphus Hall
Address 918 Druid Hill Ave
19. 9/8 1945 A. W. Kidwell Jr. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 6 1945, at 9:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
acute circulatory disease.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide NO Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave A. Faulenbach M.D.
M. D. or other
Address acting coroner Glen Burnie Md. Date signed 9/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14a)

CERTIFICATE OF DEATH

08715 23

Reg. Dist. No. .....

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Glen Burnie, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sudden (in Auto on Street)

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Pasadena R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Colonial beach Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lawson Revere

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Pearl Revere Nee Jackson deceased

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 28, 1898

8. AGE: Years 47 | Months 2 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace: Delta Ville, Middlesex Co. Va. (Town, county, and state)

10. Usual occupation: Iron Construction

11. Industry or business: Empire Engineering Co.

FATHER — 12. Name: Peter Revere

FATHER — 13. Birthplace: Middlesex Co., Va.

MOTHER — 14. Maiden name: Sarah Mason

MOTHER — 15. Birthplace: Middlesex Co., Va.

16. Informant: John Revere

Address: Delta Ville, Middlesex Co., Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: September 10, 45 (month) (day) (year)

Cemetery or crematory: Zoar Baptist Church Yard

Location: Middlesex Co., Va.

18. Funeral director: Thomas W Singleton

Address: Glen Burnie, Md

19. Sept 9 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 19 45 at 11.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from XXXXXXXX 19 to XXXXXXXX 19 XXXXXXXX and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Gustave A Rauch M.D. M. D. or other

Address: Glen Burnie, Md Date signed 9/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (36)

08716

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #3
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: ROWLEY - JOSEPH

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Mrs. Minnie Rowley

Cambridge, Md. B.(c) If alive, give age: unk. years

7. Birth date of deceased (mo., day, yr.): 1899

8. AGE: Years	Months	Days	If less than one day
46	unknown		---hrs. --min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: Parker Rowley
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Cornish
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept. 10 1945 (month) (day) (year)
Cemetery or crematory: Beckwith Neck
Location: Cambridge, Maryland

18. Funeral director: Louis Bayneum
Address: Cambridge, Maryland

19. Sept. 8 1945 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1945 at 3:00A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 1945, to Sept. 7 1945 and that I last saw him alive on September 7 1945

Immediate cause of death	DURATION
Gangrene of Left leg	3 days
Due to: General Paresis	Prior to Admission 8/28/45
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op. ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---

23. SIGNATURE: Harry J. Winfree M. D. or other
Address: Crownsville, Maryland Date signed 9/7/45

Dr Cregg

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

18717

★ Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred: 927 West St.

How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anna Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 927 West St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ********

3.(a) FULL NAME: Mary Shelter

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	****** ****** **

6.(b) Name of husband or wife: ********** ********

6.(c) If alive, give age: ***** years

7. Birth date of deceased (mo., day, yr.): August 10, 1941

8. AGE:	Years	Months	Days	If less than one day
#	4	1		..... hrs. ..... min.

9. Birthplace: Annapolis Md. A. A. Co. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER — 12. Name: William Shelter

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Agnes Johns

MOTHER — 15. Birthplace: Annapolis Md.

16. Informant: Mrs James Jones

Address: 927 West St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: September 20/45 (month) (day) (year)

Cemetery or crematory: St. Marys Cemetery

Location: West St. Extd.

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest Annapolis Md.

19. Sept 20 19 45 (Date rec'd by registrar) W. T. Brandt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9/18 19 45 at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/6/45 19 to 9/18/45 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Bacillary Dysentery	12 days
Due to Type Organism Unknown.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T. H. Johnson Md. M. D. or other

Address: 40 W. West Street Date signed: 9/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

18718

Reg. Dist. No.

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 3 months
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 year, 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -----
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1515 Winchester Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: SMITH - LILLIE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): 1879 ?

8. AGE: Years: 66 ? Months: unknown Days: If less than one day: ---hrs. ---min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laundry Worker

11. Industry or business: ------

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 8, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City

18. Funeral director: Thomas E. Kelson
Address: 1303 Presstman St., Balto., Md.

19. Sept 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1945 at 5P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 5 1944 to Sept. 5 1945 and that I last saw her alive on Sept. 5 1945

Immediate cause of death	DURATION
Apoplexia	
Due to: -------	
Due to: -------	
Other conditions: Senile Psychosis	Known to us since 6/5/44

(Include pregnancy within 3 months of death)

Major findings of operations: ------ Date of op.: -----

Autopsy results: --------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --------- Date of: ----
Where did injury occur? ---------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --------
Means of injury: --------- Injured at work? ----

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 9/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13) (22)

CERTIFICATE OF DEATH

11871 21 Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George A. J. Stinchcomb

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Elsie E. Stinchcomb
Nee Moran
6.(c) If alive, give age: 62 years
7. Birth date of deceased (mo., day, yr.): August 5-1881

8. AGE: Years	Months	Days	If less than one day
64	1	1	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)
10. Usual occupation: Ship Yard Operator
11. Industry or business
FATHER 12. Name: Thomas W. Stinchcomb
13. Birthplace: Md.
MOTHER 14. Maiden name: Henrietta Stinchcomb
15. Birthplace: Md.
16. Informant: Mrs. Elsie E. Stinchcomb
Address: Crownsville Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-8-45. (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie Md.
18. Funeral director: J. W. Singleton
Address: Glen Burnie Md.
19. Sept 7, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 10.30

20. DATE OF DEATH: Sept 6, 1945, at A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 6th 1942, 19..., to Sept 6th 45, 19...
and that I last saw h[illegible] alive on Sept 5th 45, 19...

Immediate cause of death	DURATION
Cerebral Lemmhage	1 DAY
Due to: Chronic Interstitial Nephritis	
Due to: Arterio Sclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John J. Alexander Md
M. D. or other
Address: Glen Burnie Md. Date signed 9/7/45

08720

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47

CERTIFICATE OF DEATH

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
96 East Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 96 East Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eugenia Dixon Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Daniel C. Taylor
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 9, 1886

8. AGE: Years	Months	Days	If less than one day
59	3	16	..... hrs. ..... min.

9. Birthplace: Anne Arundel Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: George W. Dixon
13. Birthplace: Calvert County, Md.

MOTHER
14. Maiden name: Marie E. Trott
15. Birthplace: Anne Arundel Co., Md.

16. Informant: Daniel C. Taylor
Address: 96 East Street - Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 27, 1945 (month) (day) (year)
Cemetery or crematory: St. Anne's Cemetery
Location: Annapolis, Md.
18. Funeral director: John M. Taylor & Son
Address: 147-149 Gloucester St. - Annap.
19. Sept. 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 25 1945, at 6:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1945 to Sept 25 1945 and that I last saw h.. alive on Sept 25 1945

	DURATION
Immediate cause of death: Cardio Vascular Failure	2 wks
Due to: Cancer of Liver	about
Due to: with a Carcinomatous	1 yr
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Oliver Pancoast M. D. or other
Address: Annapolis Md. Date signed: 9/26/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

08721

CERTIFICATE OF DEATH

★ Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 3 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 10 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: La Plata
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: -----

3. (a) FULL NAME: TAYLOR - LOUISE

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ----- years

7. Birth date of deceased (mo., day, yr.): 1907

8. AGE: Years: 38 | Months: unknown | Days: | If less than one day: ---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: -------

FATHER — 12. Name: Charles Taylor
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Hella ?
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 21, 1945 (month) (day) (year)

Cemetery or crematory:
Location: Pomfert, Maryland

18. Funeral director: Thomas Frazier
Address: Washington, D. C.

19. 9/18/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 16 1945, at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13 1944 to Sept. 16 1945 and that I last saw her alive on September 16 1945

Immediate cause of death	DURATION
General Paresis	Known to us since 11/24/44
Due to: -------	
Due to: -------	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.: ----
Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: ------- Date of: -----
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: ------- Injured at work? -----

23. SIGNATURE: Albert J. Armstead M. D. or other
Address: Crownsville, Maryland Date signed: 9/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9th)

08722

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 266 King Geo St.
(If rural give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: B. Allen Welch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Susan Welch
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 25th 1862

8. AGE:	Years	Months	Days	If less than one day
	83	5	16	hrs. min.

9. Birthplace: A A Co Md.
(Town, county, and state)
10. Usual occupation: Pres of Annapolis
11. Industry or business: Savings Bank
FATHER 12. Name: Benjamin A. Welch
13. Birthplace: Annapolis Md
MOTHER 14. Maiden name: Lucinda Pendell
15. Birthplace: A A Co Md.
16. Informant: Miss Gertrude Welch
Address: Mt Zion A A Co Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept 12th 1945 (month) (day) (year)
Cemetery or crematory: Christ Church
Location: Severnsville A A Co Md.
18. Funeral director: John M Taylor
Address: Annapolis Md
19. Sept. 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 10 1945 at 10 05 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1945 to Sept 10 1945 and that I last saw h... alive on Sept 10 1945

Immediate cause of death: Chronic myocarditis — Valvular heart disease — DURATION: Not Known

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Walton H Hughes M.D. M. D. or other
Address: Annapolis Md Date signed: 9-11-45

08723

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 195-a

CERTIFICATE OF DEATH

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 15 hours
Hospital, Institution, or other address where death occurred: Emergency Hospital
How long in hospital or institution? about 15 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 47 Calvert St
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: Charles Wilford

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	negro	

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age ——— years
7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
—	—	—	...hrs. ...min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown
FATHER 12. Name: unknown
FATHER 13. Birthplace: unknown
MOTHER 14. Maiden name: unknown
MOTHER 15. Birthplace: unknown
16. Informant: ———
Address: ———
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/7/45 (month) (day) (year)
Cemetery or crematory: Sage Bottom
Location: Spa Rd. Smithville Annapolis Md.
18. Funeral director: Mrs Charles A. Hicks
Address: 45 Northwest st Annapolis Md
19. Sept. 7 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 6 1945, at 3 25 A M
21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Postmortem Examination 19... ~~and that I last saw him alive on~~ Sept. 6 1945

Immediate cause of death	DURATION
Cerebral Embolism	sudden
Due to	
Due to Fractured Jaw Infected?	about 10 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: pending Date of ...
Where did injury occur? Annapolis (City or town) A.A. (County) ? Md. (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury not known Injured at work? no
23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed 9-6-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-C)

CERTIFICATE OF DEATH

18724

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Adams Park, Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since September 9, 1945

Hospital, Institution, or street address where death occurred:

Adams Park, Annapolis Md.

How long in hospital or institution? ********** ***

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Pennsylvia County: *********

City or town: Chester Pa.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 209 Penn. St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ********** ***

3.(a) FULL NAME: Sarah Bell Wilson

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: ********** ********** **********

6.(c) If alive, give age: ***** years

7. Birth date of deceased (mo., day, yr.): December 1884

8. AGE:	Years	Months	Days	If less than one day
	60	60		....hrs. ....min.

9. Birthplace: Essex County Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER — 12. Name: Liston Davis

FATHER — 13. Birthplace: Essex County Virginia

MOTHER — 14. Maiden name: Mollie Brockenborough

MOTHER — 15. Birthplace: Essex County Virginia

16. Informant: Mrs Julia Lewis FOOTE

Address: Adams Park, Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10/2/45 (month) (day) (year)

Cemetery or crematory: Shipped to Saluda Virginia

Location: Saluda Virginia

18. Funeral director: Mrs Charles E. Hicks

Address: 45 Northwest St. Annapolis Md.

19. Oct. 1 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 28, 1945, at 4:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 10, 1945, to September 28, 1945 and that I last saw h... alive on September 28, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R L Richardson M. D. or other

Address: 110 Clay St. Annapolis Md. Date signed 9/29/45

Dr. Klaussen

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B72)

CERTIFICATE OF DEATH

18725

★ Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A.A.
City or town: Mt. Calvary
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Richard Woodard

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Luvinia Woodard
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 13, 1879

8. AGE: Years	Months	Days	If less than one day
66	2	19	..... hrs. ..... min.

9. Birthplace: A.A.Co Md.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: John Woodard
13. Birthplace: MD.

MOTHER
14. Maiden name: Ellen ?
15. Birthplace: MD.

16. Informant: Luvinia Woodard
Address: Mt. Calvary, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 5 1945 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Cemetery
Location: Arnold, Md.

18. Funeral director: J.B. Johnson
Address: Annapolis, Md.

19. Sept. 5 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 2 1945, at 9.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 29 1945, to Sept 2 1945, and that I last saw h... alive on Sept 1 1945.

Immediate cause of death	DURATION
Uraemia	2 days
Due to: Ac. retention of urine	2 wks.
Due to: Benign Hypert. Prostate	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: M. D. Klauss, MD
M. D. or other
Address: 31 Southgate Ave. Date signed: 9/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 28

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years, 6 months, 10 days
Hospital, institution, or street address where death occurred: Crownsville State Hospital
How long in hospital or institution? 3 years, 6 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 230 N. Pearl Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME John Robert Wylie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Separated

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 6, 1910

8. AGE: Years	Months	Days	If less than one day
34	9	3	hrs. min.

9. Birthplace: S. C. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Hugh Wylie
13. Birthplace: S. C.

MOTHER
14. Maiden name: Maria Lyse
15. Birthplace: S. C.

16. Informant: Hospital records
Address: Crownsville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 12-45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location:

18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley ave

19. 9/9-45 19 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 9, 1945 at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 27, 1942 to September 9, 1945 and that I last saw h[illegible] alive on September 9, 1945

	DURATION
Immediate cause of death: General Paresis	Unknown
Due to: Syphilis	March 7, 42
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings at operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Harry J. Bruford M. D. or other
Address: Crownsville Date signed: 9-9-45